

APPLICATION FORMS AND INSTRUCTIONS FOR THE MEDICARE REPLACEMENT DRUG DEMONSTRATION

As part of the Medicare Modernization and Improvement Act of 2003 (MMA) you may be eligible to participate in a time-limited opportunity to have certain drugs covered by Medicare before Medicare's prescription drug program begins in 2006. To apply you must be currently eligible for Medicare Part A coverage, be enrolled in Medicare Part B, and live in one of the 50 United States or the District of Columbia. In addition, Medicare must be your primary insurer and you must have been diagnosed by a physician with a condition that is treated with one of the covered prescription drugs. If you do not meet these criteria you should not submit an application.

Under the Medicare Replacement Drug Demonstration people who have been diagnosed with rheumatoid arthritis, multiple sclerosis, osteoporosis, pulmonary hypertension, secondary hyperparathyroidism, Paget's Disease, Hepatitis C, CMV retinitis, or certain kinds of cancer may be eligible to have Medicare pay for certain self-administered drugs and biologicals that replace the need for drugs that are currently covered under Medicare Part B but are generally only available when provided in the doctor's office.

If you think you might be eligible to participate in this demonstration you should complete the application and have your physician complete the physician certification form and mail or fax it to the address below. Submitting an application is the only way you can be considered for participation.

Under the law, this demonstration is limited to no more than 50,000 participants and \$500 million in spending.

There are three parts to this application form:

1. *The Medicare Replacement Drug Demonstration Enrollment Form.* This is the basic application form that must be completed and signed by all applicants.
2. *The Medical Certification of Beneficiary Eligibility for the Medicare Replacement Drug Demonstration.* This form must be completed and signed by the physician (or other clinician such as a nurse practitioner) who has or will prescribe the demonstration covered medication for the applicant.
3. *The Medicare Replacement Drug Demonstration Financial Assistance Application.* This form is for a Medicare recipient who has limited income and financial resources and may qualify for additional coverage. In this case you should also complete the Financial Assistance Application form and mail it to the address below with your application. **If you do not think you qualify for financial assistance you do not need to return the Financial Assistance Application form.** However, your application will be considered without regard to whether you are applying for financial assistance.

If you have any questions about the Medicare Replacement Drug Demonstration or if you need assistance in completing the application please contact:

Medicare Replacement Drug Demonstration
c/o TrailBlazer Health Enterprises, L.L.C.
P.O. Box 5136
Timonium, MD 21094
1-866-563-5386
TTY 1-866-563-5387
FAX 410-683-2933
www.medicare.gov

PART I: ENROLLMENT FORM FOR MEDICARE REPLACEMENT DRUG DEMONSTRATION

SECTION I

First Name	Middle Initial	Last Name	Date of Birth (month/day/year)	Sex	
Residence Street Address			City	State	ZIP Code
Medicare ID Number			Telephone Number (with area code)		

SECTION II: Medicare Coverage Information

1. Do you currently have Medicare Part A? ☐ Yes ☐ No
2. Do you currently have Medicare Part B? ☐ Yes ☐ No
3. Do you receive assistance from your State Medicaid Program in paying for your Medicare Part B premium or out-of-pocket costs? ☐ Yes ☐ No

SECTION III: Other Health Insurance Information

1. Do you have other health insurance in addition to Medicare that provides coverage for outpatient drugs? ☐ Yes ☐ No
2. What other health insurance do you have that covers outpatient drugs (check all that apply)?
 - ☐ Medicaid ☐ TriCare ☐ Veteran's benefit
 - ☐ Retiree/spouse's employer health plan ☐ Privately-purchased policy (e.g., Medi-gap)
 - ☐ State or county program other than Medicaid ☐ Pharmacy company program
 - ☐ Other: (please describe) _____
3. Is there an annual dollar coverage limit to this plan?
☐ Yes ☐ No
If Yes, please specify the dollar limit: \$ _____
4. Is there a monthly limit to the number of prescriptions you can fill under this plan?
☐ Yes ☐ No
If Yes, please specify the number of prescriptions allowed per month? _____

SECTION IV: Medication Information

(Note: You must complete this page for EACH medication you are requesting. If you are requesting more than one medication, please photocopy this page before completing.)

1. What medication are you seeking coverage for under the demonstration? _____

2. Are you currently taking this medication? ☐ Yes ☐ No

3. What disease or condition do you/will you take this medication for? _____

YOUR DOCTOR OR OTHER CLINICIAN SUCH AS NURSE PRACTITIONER MUST ALSO SUBMIT A SIGNED CONFIRMATION OF THIS DIAGNOSIS BEFORE YOU CAN BE ENROLLED IN THIS DEMONSTRATION. PLEASE USE THE FORM PROVIDED FOR THIS PURPOSE.

4. If you are currently taking this medication, how have you been paying for it?

- ☐ I pay for it all myself.
- ☐ I pay for most of it myself, but some costs have been covered through insurance or a drug assistance plan.
- ☐ Most of the costs are paid by insurance or a drug assistance plan. I pay only a little or nothing at all.
- ☐ Other.

5. If you are NOT currently taking this medication and have other health insurance coverage (See Section III previous page), will this coverage pay for the drug for which you are seeking coverage under this demonstration?

- ☐ No, because I've already used up the annual dollar limit: \$ _____
- ☐ No, because I've already filled the number of prescriptions allowed each month.
- ☐ No, because this drug is not covered under my current drug plan.
- ☐ Yes, it would pay some of the costs but less than this coverage.
- ☐ I don't have other insurance.
- ☐ Other.
- ☐ Don't know.

6. If you are NOT currently taking the medication listed in question 1, are you taking another medication to treat this condition that you will stop taking if you enroll in this demonstration?

- ☐ Yes ☐ No

If Yes, what is the name of this medication? _____

7. How have you been paying for this medication?

- ☐ I pay for it all myself.
- ☐ Medicare pays for some of it and I pay some.
- ☐ Medicare pays for some and my supplemental health plan pays for the rest.
- ☐ I have a supplemental drug plan that pays some but I pay for most of it myself.
- ☐ I have a supplemental drug plan that pays for all or almost all of it.
- ☐ I am on a drug manufacturer's pharmacy assistance plan.
- ☐ Other.

SECTION V: PROXY INFORMATION

If this form is being completed on behalf of a Medicare beneficiary, please provide the following information:

Name _____

Relationship to Beneficiary _____ Phone Number (____) _____ - _____

Signature of Proxy _____ Date _____

PLEASE READ ALL OF THE INFORMATION BELOW AND SIGN AT THE BOTTOM

YOUR APPLICATION IS NOT COMPLETE WITHOUT THIS FORM BEING SIGNED

Release of Information: By applying for enrollment in this demonstration, I allow the Centers for Medicare & Medicaid Services (CMS) to give information to any organizations administering this benefit on my behalf. I also understand that, whether or not I am selected to participate in this demonstration, I may be contacted by an organization working on behalf of CMS to evaluate this demonstration.

Review of Eligibility: I understand that my application does not guarantee coverage under the demonstration and that should I be selected to participate in the demonstration, coverage may be limited to the terms and conditions of the demonstration.

I understand that my application will be considered without regard to race, color, sex, age, handicap, religion, national origin, or political belief. I agree to provide any documents necessary to confirm the accuracy and completeness of the information provided in this application. If documents are not available, I agree to give the name of the person or organization that can provide and release this necessary information.

By signing below, I certify that I have read and understand the information on this enrollment form. (If you cannot sign, a representative may sign for you.) Federal law provides for a fine or imprisonment, or both, for any person who withholds or gives false information to obtain assistance to which (s)he is not entitled.

I understand the questions on this application and I certify, under penalty of perjury, that the information given by me on this form is correct and complete to the best of my knowledge.

Signature of Beneficiary _____ Date _____

Signature of Person
Completing this Form _____ Date _____

Return completed application to: Medicare Replacement Drug Demonstration, c/o TrailBlazer Health Enterprises, L.L.C., P.O. Box 5136, Timonium, MD 21094 or fax to: 410-683-2933

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0924. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

**PART II: MEDICAL CERTIFICATION OF BENEFICIARY ELIGIBILITY
FOR MEDICARE REPLACEMENT DRUG DEMONSTRATION**

Dear Prescribing Clinician:

Your patient has applied to participate in a Medicare demonstration that will provide coverage for certain self-administrable drugs and biologicals that are replacements for drugs that are covered under Medicare Part B. Eligibility for this demonstration, is not contingent upon whether the beneficiary is currently taking any specific drug, but only that the beneficiary has a condition for which you have prescribed, or plan to prescribe if your patient is selected to participate in this demonstration, a drug that is covered under the demonstration for that condition. Some of the questions below are for the purposes of collecting descriptive information only about beneficiaries who are applying for this demonstration in order to support a Report to Congress that is mandated under the law. All beneficiary specific information will be kept strictly confidential.

The list of drugs and conditions covered under the demonstration is attached. If accepted to participate in this demonstration, the beneficiary will receive assistance from Medicare to help pay for these medications. The beneficiary may be required to pay certain deductibles or coinsurance although assistance for low-income beneficiaries is available. For more information about this demonstration, please contact 1-866-563-5386 (TTY 1-866-563-5387) or visit our web site at <http://www.cms.hhs.gov/researchers/demos/drugcoveredemo.asp>.

By signing below, you are certifying that this patient has the condition indicated and that you have prescribed or intend to prescribe this drug for this condition in accordance with demonstration requirements. Your signed certification is necessary for the beneficiary's application to participate in this demonstration to be complete. Incomplete applications will not be considered. Due to limited funds and enrollment capacity, completion of an application is not a guarantee of coverage under the demonstration.

Completed applications should be returned to: Medicare Replacement Drug Demonstration, c/o TrailBlazer Health Enterprises, L.L.C., P.O. Box 5136, Timonium, MD 21094 or fax to: 410-683-2933.

PATIENT INFORMATION

Last Name	First Name	Middle Name	Patient's Phone	Medicare ID#
Date of Birth (mm/dd/yyyy)	Drug Prescribed / To be Prescribed			NDC Code (if available)
Condition Treated (ICD9 Code – if available)		Disease Stage (if applicable)	Is Patient Homebound <input type="checkbox"/> Yes <input type="checkbox"/> No	

Will this medication replace an existing Part B covered drug the patient is or has taken?

- ☐ Yes. Drug Replaced: _____
- ☐ No. This prescription does not replace a Medicare Part B covered medication this patient is taking or has taken.

Is this or would this be a new prescription?

- ☐ Yes, this is a new prescription.
- ☐ No, patient is currently taking this medication

PRESCRIBING CLINICIAN INFORMATION (print)

Last Name	First Name	Middle Name	DEA #	Phone
Signature				Date (mm/dd/yyyy)

**DRUGS COVERED UNDER THE
MEDICARE REPLACEMENT DRUG DEMONSTRATION**

Demonstration Covered Indication	Drug/Biological—Compound Name (Brand Name)
Acromegaly	Pegvisomant (Somavert)
Ankylosing Spondylitis	Etanercept (Enbrel)
CMV Retinitis	Valcyte (Valganciclovir)
Hepatitis C	Pegylated interferon alfa-2a (Pegasys)
	Pegylated interferon alfa-2b (PEG-Intron)
Multiple Sclerosis	Glatiramer acetate (Copaxone)
	Interferon beta –1a (Rebif, Avonex)
	Interferon beta –1b (Betaseron)
	H.P. Acthar Gel <i>(for patients with recurring or remitting acute exacerbations or painful flare-ups associated with multiple sclerosis)</i>
Paget's Disease	Alendronate (Fosamax)
	Risedronate (Actonel)
Post Menopausal Osteoporosis <i>(patient must be homebound)</i>	Calcitonin – nasal (Miacalcin – nasal)
	Risedronate (Actonel)
	Alendronate (Fosamax)
	Raloxifene hydrochlorid (Evista)
Psoriasis	Efalizumab (Raptiva)
	Etanercept (Enbrel)
Psoriatic Arthritis	Etanercept (Enbrel)
Pulmonary Hypertension	Bosentan (Tracleer)
Rheumatoid Arthritis	Adalimumab (Humira)
	Anakinra (Kineret)
	Etanercept (Enbrel)
Secondary Hyperparathyroidism	Doxercalciferol (Hectoral)
Anti-Cancer Drugs	
Breast Cancer <i>(stage 2-4 only)</i>	Anastrozole (Arimidex)
	Exemestane (Aromasin)
	Letrozole (Femara)
	Tamoxifen (Nolvadex)
	Toremifene (Fareston)
Chronic Myelogenous Leukemia	Imatinib Mesylate (Gleevec)
Cutaneous T-cell Lymphoma	Bexarotene (Targretin)
Epithelial ovarian cancer	Altretamine (Hexalen)
GI Stromal Tumor	Imatinib Mesylate (Gleevec)
Multiple Myeloma	Thalidomide (Thalomid)
Non-small cell lung cancer	Gefitinib (Iressa)
	Erlotinib HCI (Tarceva)
Prophylactic agent to reduce ifosfamide-induced hemorrhagic cystitis	Mesna (Mesnex)

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0924. The time required to complete this information collection is estimated to average 2 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

PART III: MEDICARE REPLACEMENT DRUG DEMONSTRATION FINANCIAL ASSISTANCE APPLICATION

If your annual income is less than 150% of the Federal poverty level and you have other financial resources worth less than \$10,000, for an individual, (\$20,000 for a couple), you may qualify for financial assistance under this demonstration.

There are five different benefit categories under this demonstration. There is a standard benefit level and, for those with limited incomes and financial resources, four different levels of benefit subsidy corresponding to different income levels. Each benefit category has a different type of cost sharing as shown in Table 1. Table 2 shows which benefit category you are eligible for, depending upon your annual income and financial resources.

If you are receiving assistance from your State Medicaid program in paying for your Medicare Part B premiums or out-of-pocket costs, you may be eligible for coverage under Benefit Level 3.

In order for us to determine whether you qualify for any of these enhanced benefit levels, please provide us with the information requested on this form about your annual income and other financial resources. Your signature at the bottom of the form will attest that this information is true and accurate to the best of your knowledge.

If you do not believe that you qualify for low-income assistance or do not wish to complete this form, you may still be eligible to enroll in this demonstration and receive the standard benefit package. Just complete the regular enrollment application and send it to the address indicated.

For more information, please contact 1-866-563-5386 (TTY 1-866-563-5387).

TABLE 1: MEDICARE REPLACEMENT DRUG DEMONSTRATION

Benefit Categories

	Benefit Level 1 (<i>Standard</i>)	Benefit Level 2²	Benefit Level 3	Benefit Level 4	Benefit Level 5
Annual Deductible	<ul style="list-style-type: none"> In 2005: \$250 	<ul style="list-style-type: none"> In 2005: \$50 	\$0	\$0	\$0
After the annual deductible, you pay this amount for each prescription until you have reached the specified out-of-pocket limit¹:	<p>In 2005:</p> <ul style="list-style-type: none"> 25% coinsurance until you have paid \$500 in additional out-of-pocket costs and then, 100% of all costs until you have reached the out-of-pocket limit of \$3,600 (i.e., the next \$2,850 in allowable costs out of pocket) 	<ul style="list-style-type: none"> 15% coinsurance 	<ul style="list-style-type: none"> A fixed co-payment of \$2 for generic or preferred multi-brand drugs or \$5 for all other drugs 	<ul style="list-style-type: none"> A fixed co-payment of \$1 for generic or preferred multi-brand drugs or \$3 for all other drugs 	You pay nothing
Once you have paid \$3,600 in total out of pocket costs, you pay this amount for each prescription	<p>The greater of:</p> <ul style="list-style-type: none"> 5% or A fixed co-payment of \$2 for generic or preferred multi-brand drugs or \$5 for all other drugs 	<p>You pay:</p> <ul style="list-style-type: none"> A fixed co-payment of \$2 for generic or preferred multi-brand drugs or \$5 for all other drugs 	You pay nothing	You pay nothing	You pay nothing

¹Any amount paid by other insurance, with the exception of a State pharmacy assistance program or certain charitable organizations may NOT be counted toward your out of pocket limit.

²For Benefit Level 2, out of pocket payments from both Medicare and the beneficiary count towards \$3,600 catastrophic limit.

TABLE 2: ARE YOU ELIGIBLE FOR FINANCIAL ASSISTANCE?

Total Financial Resources are → And Your income is: ↓	Less than: • \$6,000 for an individual, or • \$9,000 for a couple	Between • \$6,000 and \$10,000 for an individual, or • \$9,000 and \$20,000 for a couple	Over • \$10,000 for an individual, or • \$20,000 for a couple
Less than 100% of the Federal Poverty Level (FPL) and you are a full benefit dual Medicare and Medicaid eligible beneficiary (1)(2)	Benefit Level 4	Benefit Level 4	Benefit Level 4
100% or more than the FPL and you are a full benefit dual Medicare and Medicaid eligible beneficiary (1)(2)	Benefit Level 3	Benefit Level 3	Benefit Level 3
Less than 135% of the FPL and you are not a full benefit dual Medicare and Medicaid eligible beneficiary	Benefit Level 3	Benefit Level 2	Benefit Level 1
135% or more of the FPL but less than 150% of the FPL and you are not a full benefit dual Medicare and Medicaid eligible beneficiary	Benefit Level 2	Benefit Level 2	Benefit Level 1
150% or more of the FPL and you are not a full benefit dual Medicare and Medicaid eligible beneficiary	Benefit Level 1	Benefit Level 1	Benefit Level 1

Notes:

- (1) Institutionalized full benefit dual Medicare and Medicaid eligible beneficiaries will be covered under Benefit Level 5 (See Table 2).
- (2) Most full benefit dual Medicare and Medicaid eligible beneficiaries receive a comprehensive drug benefit through the Medicaid program. Only beneficiaries who do not already have a comprehensive drug benefit through their Medicaid program are eligible to participate in this demonstration.

FEDERAL POVERTY LEVEL GUIDELINES 2005

	100 % of Federal Poverty Level		135% of Federal Poverty Level		150% of Federal Poverty Level	
	Individual	Couple	Individual	Couple	Individual	Couple
Lower 48 States	\$9,570	\$12,830	\$12,919	\$17,320	\$14,355	\$19,245
Alaska	\$11,950	\$16,030	\$16,133	\$21,641	\$17,925	\$24,045
Hawaii	\$11,010	\$14,760	\$14,864	\$19,926	\$16,515	\$22,140

MEDICARE REPLACEMENT DRUG DEMONSTRATION ATTESTATION OF INCOME AND FINANCIAL RESOURCES

Determination of eligibility for this demonstration follows income and financial resource guidelines established by the Social Security Administration. Certain income and resources may be excluded when reporting income and resources. For a complete list of what should be included and excluded, please refer to the attached guidelines or contact your local Social Security Office.

SECTION I: Beneficiary Identification

First Name	Middle Initial	Last Name	Social Security Number	
Residence Street Address		City	State	ZIP Code
Phone Number			Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	

If married, please provide the following information about your spouse.

Spouse's First Name	Middle Initial	Last Name	Social Security Number
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Is this a private residence or an institution such as a nursing home?

☐ Private Residence

☐ Nursing Home

☐ Other (please describe) _____

SECTION II: Annual Income *(If married, include both your income and spouse's income)*

1. What is your annual earned income? →

Include salary you receive from paid employment.

2. What is your annual unearned income? →

Include income from such sources as Social Security, Railroad Retirement or other pension/retirement benefits, veterans' benefits, trust or annuity payments, interest, rental income, dividends, royalties, etc.

SECTION III: Resources *(If married, include resources belonging to both you and your spouse.)*

1. Do you, or your spouse, own or co-own any of the following: savings accounts, checking accounts, government bonds, trust funds, savings bonds, stocks or bonds, certificates of deposit, IRAs, life insurance policies, recreational vehicles, etc? ☐ Yes ☐ No

If YES, what is the cash value of these items? →

2. Do you, or your spouse, own all or part of any real estate **in which you do NOT live?** ☐ Yes ☐ No

If YES, what is the value of this real estate after excluding any outstanding loans? →

3. Do you, or your spouse, own or co-own more than one vehicle for transportation? ☐ Yes ☐ No

If YES, what is the cash value of these items after excluding any outstanding loans? →

PLEASE READ ALL OF THE INFORMATION BELOW AND SIGN AT THE BOTTOM

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Review of Eligibility: I understand that my application does not guarantee coverage under the demonstration and that should I be selected to participate in the demonstration, coverage may be limited to the terms and conditions of the demonstration.

I understand that my application will be considered without regard to race, color, sex, age, handicap, religion, national origin, or political belief. I agree to provide any documents necessary to confirm the accuracy and completeness of the information provided in this application. If documents are not available, I agree to give the name of the person or organization that can provide and release this necessary information.

By signing below, I certify that I have read and understand the information on this enrollment form. (If you cannot sign, a representative may sign for you.) Federal law provides for a fine or imprisonment, or both, for any person who withholds or gives false information to obtain assistance to which (s)he is not entitled.

I understand the questions on this application and I certify, under penalty of perjury, that the information given by me on this form is correct and complete to the best of my knowledge.

Signature of Beneficiary _____ Date _____

Signature of Person
Completing this Form _____ Date _____

Relationship
to Beneficiary _____ Phone Number _____

**Completed forms should be returned to: Medicare Replacement Drug Demonstration
c/o TrailBlazer Health Enterprises, L.L.C.
P.O. Box 5136
Timonium, MD 21094
OR
FAX 410-683-2933**

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INCOME AND RESOURCE EXCLUSIONS

1. Earned Income Exclusions

- Any refund of Federal income taxes received under section 32 of the Internal Revenue Code (relating to **earned income tax credit**) and any payment received under section 3507 of the Internal Revenue Code (relating to advance payment of earned income tax credit);
- Any refundable child tax credit (which increases gradually from the current amount of \$600 for each child to \$1,000 per child in 2010);
- Up to \$10 of earned income in a month if it is **infrequent or irregular**, that is, if it is received only once in a calendar quarter from a single source or if its receipt cannot reasonably be expected. (If the total amount of the infrequent or irregular income exceeds \$10, this exclusion cannot be used.);
- Up to \$1,340 per month but not more than \$5,410 in a calendar year received by a blind or disabled child who is a student regularly attending school;
- Any portion of the monthly \$20 exclusion for unearned income that has not been used;
- \$65 of earned income in a month;
- Amounts used to pay **impairment-related work expenses** if a recipient is disabled (but not blind) and under age 65 or is disabled (but not blind) and receiving SSI (or disability payments under a former State plan) before age 65¹;
- One-half of remaining earned income in a month;
- Earned income used to meet any expenses reasonably attributable to the earning of the income if the recipient is blind and under age 65 or if he/she received SSI as a blind person prior to age 65¹;
- Any earned income received and used to fulfill an approved **plan to achieve self-support** if the recipient is blind or disabled and under age 65 or is blind or disabled and received SSI as a blind or disabled individual in the month before he/she attained age 65¹;
- Any earned income deposited into either a **Temporary Assistance for Needy Families (TANF)** or “Assets for Independence Act” **individual development account (IDA)**; and
- Some Federal laws other than the Social Security Act provide for the exclusion of earned income for SSI purposes. For the most part, the income received under these laws relates to assistance received in the form of food, housing and utilities, educational and employment benefits or benefits derived from being a member of a Native American tribe. A complete list of laws which exclude earned income under SSI can be found in the Federal Regulations Appendix to Subpart K 20 CFR 416.

2. Unearned Income Exclusions

- Any public agency’s refund of taxes on real property or food;
- **Assistance based on need** which is wholly funded by a State or one of its political subdivisions. This includes State supplementation of Federal SSI benefits but does not include payments under a Federal/State grant program such as TANF;
- Any portion of a grant, scholarship or fellowship used for paying tuition, fees or other necessary educational expenses. Portions set aside for food, clothing or shelter are counted;
- Food raised by a **household** if it is consumed by that household;
- Assistance received under the Disaster Relief and Emergency Assistance Act and assistance provided under any Federal statute because of a catastrophe which the President of the United States declares to be a major disaster;

¹ Amounts used to pay impairment-related work expenses are deducted before the one-half of earned income deduction, whereas amounts used to pay the work expenses of the blind are deducted after the one-half of earned income deduction. In effect, amounts of blind work expenses reduce SSI earned income twice as much as the same amounts of impairment-related work expenses.

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- Up to \$20 of unearned income in a month if it is infrequent or irregular; that is, if a type of unearned income is received only once during a calendar quarter from a single source or if it cannot reasonably be expected;
 - Any unearned income received and used to fulfill an approved plan to achieve self-support if the recipient is blind or disabled and under age 65 or is blind or disabled and received SSI as a blind or disabled individual in the month before he/she attained age 65;
 - Periodic payments made by a State under a program established before July 1, 1973, and based solely on the recipient's length of residence and attainment of age 65;
 - Payments for providing foster care to an ineligible child who was placed in the recipient's home by a public or private nonprofit child placement or child care agency;
 - Any interest earned on excluded **burial funds** and any appreciation in the value of an excluded burial arrangement which are left to accumulate and become part of the separately identifiable burial fund;
 - Certain support and maintenance assistance provided in the form of **home energy assistance**;
 - One-third of support payments made by an absent parent if the recipient is a child;
 - The first \$20 of unearned income in a month other than income in the form of in-kind support and maintenance received in the household of another and income based on need;
 - The value of any assistance paid with respect to a dwelling unit under the United States Housing Act of 1937, the National Housing Act, section 101 of the Housing and Urban Development Act of 1965, title V of the Housing Act of 1949, or section 202(h) of the Housing Act of 1959;
 - Any interest accrued on and left to accumulate as part of the value of an excluded burial space purchase agreement (after April 1, 1990);
 - The value of any commercial transportation ticket, for travel by a recipient or his/her spouse among the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa and the Northern Mariana Islands, which is received as a gift and is not converted to cash;
 - Payments received from a fund established by a State to aid victims of crime;
 - Relocation assistance provided by a State or local government that is comparable to assistance provided under title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970;
 - Hostile fire pay received from one of the uniformed services pursuant to 37 U.S.C. 310 and other kinds of additional pay received by military personnel in a combat zone;
 - Interest or other earnings on a **dedicated account** excluded from resources;
 - In-kind gifts not converted to cash and the first \$2,000 annually of cash gifts made by tax-exempt organizations, such as the Make-A-Wish Foundation, to, or for the benefit of, individuals under age 18 with life-threatening conditions;
 - Payments made under the Ricky Ray Hemophilia Relief Fund Act of 1998;
 - TANF funds made available to an SSI recipient as part of an individual development account (IDA);
 - Deposits made by a participating individual or a sponsoring nonprofit organization or State or local government into an IDA under the "Assets for Independence Act" IDA demonstration project and interest earned on these deposits; and
 - Unearned income excluded by other Federal laws. See Federal Regulations Appendix to Subpart K 20 CFR 416.

3. Resource Exclusions

- The home (including the land appertaining thereto);
- Household goods and personal effects to the extent that their total value does not exceed \$2,000;
- An automobile may be totally excluded if: (1) it is necessary for employment; (2) it is necessary for the medical treatment of a specific or regular medical problem; (3) it is modified for the operation by or transportation of, a handicapped individual; or (4) it is necessary to perform essential daily activities. If the automobile does not meet any of the above requirements, it may be excluded to the extent that its current-market value does not exceed \$4,500;
- Property of a trade or business which is essential to the means of self-support;
- Nonbusiness property which is essential to the means of self-support;
- Resources of a blind or disabled individual which are necessary to fulfill an approved plan for achieving self-support;
- Stock in regional or village corporations held by natives of Alaska during the 20-year period in which the stock is inalienable pursuant to the Alaska Native Claims Settlement Act;
- Life insurance owned by an individual (and spouse, if any) provided that all life insurance on any person does not exceed a face value of \$1,500;
- Restricted allotted Indian lands;
- Disaster relief assistance;
- Burial spaces and certain funds up to \$1,500 for burial expenses;
- Title XVI or Title II retroactive payments (for 6 months following receipt);
- Housing assistance;
- Refunds of Federal income taxes and advances made by an employer relating to an earned income tax credit, (for the month following receipt);
- Refundable child tax credit (\$600 per child in the current year, gradually increasing to \$1,000 per child in 2010) in the month of receipt and in the following month;
- Payments received as compensation for expenses incurred or losses suffered as a result of a crime (for 9 months);
- Relocation assistance from a State or local government (for 9 months);
- Dedicated financial institution accounts for disabled children;
- In-kind gifts not converted to cash and the first \$2,000 annually of cash gifts made by tax-exempt organizations, such as the Make-A-Wish Foundation, to, or for the benefit of, individuals under age 18 with life-threatening conditions;
- Payments made under the Ricky Ray Hemophilia Relief Fund Act of 1998;
- Amounts deposited into either a TANF or "Assets for Independence Act" IDA, including matching funds and interest earned on such amounts;
- Certain **trusts** (e.g., those established by will or certain Medicaid trusts that will repay the State, upon the death of the beneficiary, for the costs of medical assistance provided to that individual); and
- Payments or benefits provided under a Federal statute other than Title XVI of the Social Security Act where exclusion is provided by such statute.